MEDPAC Medicare Payment Advisory Commission

MEETING BRIEF

March 20-21, 2003

Using incentives to improve quality in Medicare

ISSUE: Should Medicare expand its use of incentives to improve quality of care? Should financial incentives be explored? In the private sector, a growing number of payers provide financial recognition of high quality. Some early results from the private payers' experience suggest that using both financial and non-financial incentives, perhaps in tandem, can be effective.

KEY POINTS: Medicare already uses non-financial incentives for quality in some segments of the program, but generally, the current payment system is neutral toward quality and fails to reward plans or providers who improve quality. In this report, we will discuss the most prevalent ways private payers have been trying to increase quality: public disclosure, payment differentials for providers, and cost differences for enrollees. Our analysis of their design and implementation process has yielded five criteria for successful incentives.

- Goals must be well-defined, broadly understood, and accepted.
- Measures should reflect a broad spectrum of the services beneficiaries receive from the provider.
- Providers or plans must be able to improve upon the aspect of quality measured.
- Incentives must not create access problems for riskier or more complex patients.
- Obtaining information must not impose an excessive burden.

ACTION: This paper and presentation is the third in a series that began last year with a panel of private payers discussing their experiences and results with using incentives. The series will conclude next month with a final chapter for the June report.

At this meeting, the Commission should discuss several key questions and potential recommendations.

1. Medicare is already using non-financial incentives and working to build the infrastructure necessary for use of financial incentives to improve quality. Should Medicare go a step farther and develop and demonstrate financial incentives, such as provider payment differentials and cost differentials for beneficiaries?
2. If so, how should CMS use their demonstration authority to design strategies to evaluate these financial incentives? Staff propose that the Commission recommend that CMS use the criteria that emerged from our research to focus their demonstration efforts.
3. If the Commission recommends that Medicare should consider these financial incentives, what settings or types of care should the program focus on and how should the incentives be designed? (Staff will provide more detail on this question in April.)

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